Julie L. Molin, D.M.D. ~ Family & Cosmetic Dentistry
17 Globe Court Red Bank, NJ 07701 732-741-8040 (p)
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AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

TO: _____ FAX: _____

PATIENT NAME:_____DOB: _____

RELEASE TO: Dr Julie Molin DMD , 17 Globe Court Red Bank, NJ 07701

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED:

_____Copy of complete dental chart condition described below:
_____Copy of dental x-rays
_____All treatment rendered _____
_____Others

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____Transfer of Records _____Second Opinion

_____Other, please explain_____

AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it.

_____
Patient Name (Print)

_____

Signature Date

Please email digital x-rays to frontdesk@juliemolin.com